National Indian Health Board

TESTIMONY FOR THE RECORD OF THE NATIONAL INDIAN HEALTH BOARD – THE PRESIDENT'S FY2020 BUDGET REQUEST FOR INDIAN PROGRAMS
May 8, 2019, 2:30PM

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, the National Indian Health Board (NIHB) thanks you for holding this hearing on, "The President's FY2020 Budget Request for Indian Programs." On behalf of NIHB and the 573 federally-recognized Tribes we serve the National Indian Health Board submits this testimony for the record. NIHB is a 501(c)3, not for profit, national Tribal organization founded by the Tribes in 1972 to serve as the unified, national voice for American Indian and Alaska Native (AI/AN) health in the policy-making arena. Our Board of Directors is comprised of distinguished and highly respected Tribal leaders in AI/AN health. They are elected by the Tribes in each region to be the voice of the Tribes at the national level.

The Federal Trust Responsibility

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the unique trust relationship between the United States and Tribes.

The Indian Health Service (IHS) is the primary agency by which the federal government meets the trust responsibility for direct health services. IHS provides services in a variety of ways: directly, through agency-operated programs and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations. Tribes may choose to receive services directly from IHS, run their own programs through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Today the Indian Health Service system is comprised of 45 hospitals (26 IHS operated, 19 Tribal) and 531 outpatient facilities (76 IHS operated, 476 Tribal). At these facilities there were an estimated 39,367 inpatient admission and 13.8 million outpatient visits in 2018.[1] When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. To ensure accountability and provide greater access for Tribal input, IHS is divided into 12 geographic Service Areas, each serving the Tribes within the Area. It is important to note that Congress has funded IHS at a level far below patient need since the agency's creation in 1955. In FY 2017, national health spending was $9,726 per capita while IHS spending was only $4,076 per patient.

The federal government has yet to live up to the trust responsibility to provide adequate health services to our nation's indigenous peoples. Historical trauma, poverty, lack of access to healthy foods, loss of culture and many other social, economic and environmental determinants of health as well as lack of a developed public health infrastructure in Indian Country all contribute to the poor state of American Indian and Alaska Native (AI/AN) health. This underfunding of the IHS is clearly visible when

[1] Source: Indian Health Service. IHS Profile Fact Sheet. Located at: https://www.ihs.gov/newsroom/factsheets/ihsprofile/

examining the health disparities for AI/ANs. A national study looking at death certificate data reported that AI/AN experienced the highest prescription opioid death rate of any demographic in 2017 at 7.2 deaths per 100,000.From 1999 to 2015 drug overdose deaths overall rose by 519% for AI/ANs.[2] According to the Office of Minority Health, from 2009-2013, AI/AN men were almost twice as likely to have liver and inflammatory bowel disease (IBD) cancer as non-Hispanic White men and are 1.6 times as likely to have stomach cancer as non-Hispanic White men, and are over twice as likely to die from the same disease. AI/AN women are 2.5 times more likely to have, and almost twice as likely to die from, liver and IBD cancer, as compared to non-Hispanic White women. In 2015, AI/ANs were three times more likely to die from hepatitis C than non-Hispanic whites, and twice as likely to die from hepatitis B. In 2016, AI/ANs had the highest overall suicide death rate at 21.39 deaths per 100,000.[3] According to National Violent Death Reporting System data analyzed by CDC across 18 states, AI/AN suicide rates in those states were at 21.5 per 100,000 – more than 3.5 times the rate among demographics with the lowest rates.[4]

In FY 2017, the IHS per capita expenditures for patient health services were just $4,076, as compared to $8,109 for Medicaid, $10,692 for VHA, and $13,185 for Medicare. The Veterans' Health Administration's direct health care budget is 14 times that of the IHS yet served only 4 times the population with direct care services.

Tribes are grateful for the recent increases to the IHS Appropriation over the last several years, but note that the increases have not allowed for significantly expanded services or improvements in equipment, buildings or staffing. While the IHS annual appropriated budget has incrementally grown by $2.2 billion (about 52%) since FY 2008, much of this increase simply covers needs associated with population growth, inflation, full funding of Contract Support Costs and maintaining current services. This leaves little funding for actual improvements in health services or to build public health infrastructure for American Indians and Alaska Natives. We are only 2% of the population. Congress, please take the courageous and ethical step of adequately funding health care for this country's first peoples in fulfilment of the Trust Responsibility.

The following testimony reflects the IHS Tribal Budget Formulation Workgroup recommendations for FY 2020.[5] The Tribal workgroup is comprised of American Indian and Alaska Native Tribal leaders, technicians and researchers, nationwide, who come together each year to form Indian Country's priorities as they relate to IHS. Through this process and product, this testimony reflects, therefore, the national Tribal voice.

Indian Health Service Budget

[2] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12.
DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

[3] Suicide Prevention Resource Center. Racial and Ethnic Disparities. Retrieved from http://www.sprc.org/racial-ethnic-disparities
[4] Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242.
DOI: http://dx.doi.org/10.15585/mmwr.mm6708a1
[5] The full FY 2020 Tribal Budget Request is available athttps://www.nihb.org/legislative/budget_formulation.php

Tribes recommend **$36.8 billion** to fully fund IHS, to be phased in over 12 years. This includes amounts for personal health services, wrap-around community health services, facilities, and capital investments. For FY 2020 this includes: **$189.1 million** for full funding of current services; **$275 million** for binding fiscal obligations[6]; **$1.5 billion** for program increases for the most critical health issues (36% above FY 2017 enacted). The Workgroup's top 5 areas for program expansion at IHS for FY 2019 include:

1) Hospitals and Clinics (+ $409 Million)
2) Purchased/Referred Care (+ $407 Million)
3) Mental Health (+ $157.2 Million)
4) Alcohol and Substance Abuse (+ $123.8 Million) and;
5) Dental Services (+ $98.3 Million)

Hospitals and Clinics – For FY 2020, Tribes recommend **$2.5 billion** for Hospitals and Clinics (H&C) which is $409 million over the FY 2017 enacted level. Adequate funding for the Hospitals & Clinics (H&C) line item is the top priority for fiscal year 2020, as it provides the base funding for the 650 hospitals, clinics, and health programs that operate on Indian reservations, predominantly in rural and frontier settings. This is the ***core funding*** that makes available direct medical care services to AI/ANs. Increasing H&C funding is necessary as it supports medical care services provided at IHS and Tribally-operated facilities, including emergency care, inpatient and outpatient care, medically necessary support services, such as laboratory, pharmacy, digital imaging, information technology, medical records and other ancillary services. In addition, H&C funds provide the greatest flexibility to support the required range of services needed to target chronic health conditions affecting AI/ANs such heart disease and diabetes, treatment and rehabilitation due to injuries, maternal and child health care and communicable diseases including influenza, HIV/AIDS, and hepatitis.

Health IT: One area within the H&C line item is the area of Health Information Technology (HIT). IHS does not receive dedicated and sustainable funding for the agency to adequately support health IT infrastructure, including full deployment of electronic health records (EHRs). The current Resource and Patient Management System (RPMS) is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most Tribal facilities. The President's Budget for FY 2020 requests $25 million for IHS, "to begin to transition to a new and modernized Electronic Health Record System." It notes that the funding will help "lay the groundwork" for improving Health IT at the agency. This recommendation is appreciated due to the lack of funding that has resulted in a mass exodus of Self Governance Tribes who have opted to withdraw their IT shares to seek other commercial HIT solutions which promise to more readily address their needs. Without a viable solution, IHS Health IT system will be left behind, and IHS patients will be put at risk. With the VA's move toward a commercial-off the shelf EHRs, it is critical that IHS receive parallel appropriations to facilitate the replacement of RPMS, since our system is based on VA's VistA program. It is unlikely that appropriate funding will be available only through Interior Appropriations; therefore, alternative sources of funding must be secured.

Purchased/Referred Care – In FY 2020, Tribes recommend **$1.39 billion** for the Purchased/Referred Care (PRC) program. This is $407 million above the FY 2017 enacted level. The PRC budget supports essential health care services from non-IHS or non-Tribal providers. In FY 2015, PRC denied over

[6] Includes placeholder estimates for Contract Support Costs (CSC) and staffing for new facilities and new Tribes

$423.6 million in services – that is 92,354 needed health care services that AI/ANs were denied from receiving. This core funding is still a top priority for the Tribes, as some service Areas rely heavily on PRC dollars, and we hope to see it continued as a priority in FY 2020. These deferrals impact real lives and constitute health care rationing for American Indian and Alaska Native patients. The shortage of PRC funds directly contributes to the opioid crisis in Tribal communities as evidenced through pain management regiments vs. needed treatment for painful injuries – such as those that could be treated through othoepadic care. Indeed, the deferrals of care due to funding and workforce shortages has pushed more and more Tribal members towards prescription opioids to treat health conditions that would otherwise successfully be treated with non-opioid therapies. This endless cycle of deferral and opioid dependency is a direct result of the underfunding of the IHS system, and must be addressed

Mental Health – In FY 2020, Tribes are recommending **$254,730 million**. This is $157.2 million above FY 2017 enacted. This increase would mean a 167% increase in funding for behavioral health services in Indian Country. A significant increase is needed to enhance the capacity of Tribal communities to develop innovative and culturally relevant prevention programs that are greatly needed in Tribal communities. Research has shown that AI/ANs do not prefer to seek mental health services that rely solely upon Western models of care; which suggests that AI/ANs are not receiving the services they need.[7] For example, NIHB spoke with a young woman from the Pine Ridge Reservation who courageously shared her story about her multiple suicide attempts. She went to an inpatient psychiatric facility in Rapid City, but did not feel that she received healing. It wasn't until she attended a Lakota cultural healing camp that her life turned around. She said, "It made me feel powerful. I got to learn about my culture and it made me feel closer to who I am." But the camp operates through donations and community support. Congress should provide dedicated funding for these types of culturally relevant and effective treatment options. The geographic remoteness of most Tribal communities demands unique and innovative treatment options to address comprehensive mental health, substance abuse and psychiatric services.

Alcohol and Substance Abuse – In FY 2020, Tribes recommend **$351,237 million** for the Alcohol and Substance Abuse budget. This is $123.7 million above the FY 2017 enacted level. Of the challenges facing AI/AN communities and people, no challenge is more far reaching than the epidemic of alcohol and other substance abuse. For instance, the state of Minnesota reported that pregnant AI/AN women were 8.7 times more likely to be diagnosed with maternal opioid dependency, and that AI/AN infants were 7.4 times more likely to be born with neonatal abstinence syndrome (NAS) – meaning that the repercussions and trauma of this crisis are intergenerational. When IHS programs are not able to receive patients when an addict is ready, this is where he or she falls through the cracks. We need these funds to increase access to care when and where it is needed. Adult and youth residential facilities and placement contracts with third party agencies are funded through IHS budget for alcohol and substance abuse treatment. Successful treatment approaches include traditional healing techniques that link the services provided to cultural practices and spiritual support. However, we now know that inadequate funding for

[7] Beals, J., Novins, D.K., Whitesell, N.R., Spicer, P., & Mitchell, C.M., & Manson, S.M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations: Mental Health disparities in a national context. *American Journal of Psychiatry, 162,* 1723-1732.

Walls, M. L., Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2006). Mental health and substance abuse services preferences among American Indian people of the northern Midwest. *Community Mental Health Journal, 42*, 521 -535.

alcohol and substance abuse services has a ripple effect on other services, such as overloading the agency's outpatient clinics, urgent care departments, and emergency departments with unnecessary visits (typically funded by Hospitals and Health Clinic funds and third party collections).

Dental Health – For FY 2020, Tribes recommend **$288 million** for Dental Health. This is $98.3 million above the FY 2017 enacted level. In the general U.S. population, there is one dentist for every 1,500 people, but in Indian Country, there is only one dentist for every 2,800 people. Nationally, American Indian children have the highest rate of tooth decay than any population group in the country. On the Pine Ridge Reservation, the W.K. Kellogg Foundation found that 40% of children and 60% of adults suffer from moderate to urgent dental needs, including infections and other problems that could become life-threatening. Nationally, 59% of AI/AN adult dental patients have untreated decay, this is almost three times as much as U.S Whites. It is not uncommon to hear stories of elderly patients waiting out in the cold for one of just a few dental appointments available in one day. Or, for patients to wait for months to get an appointment. Patients get frustrated with this system and often abandon the search for care altogether. This delayed or deferred care has long-term impacts over a patient's overall health and wellbeing. NIHB and the Tribes continue to support the expansion of Dental Therapists (DTs) to Tribes outside of Alaska as a safe, reliable, cost-effective means for Tribal members to access oral health services. Some Tribes in the lower 48 have created programs outside of IHS funding to allow them to utilize DTs, but sadly, provisions in the Indian Healthcare Improvement Act (IHCIA)[8] make it difficult to use IHS resources to use these effective providers. People with healthy teeth and healthy smiles feels better about themselves and experience better overall health outcomes. Our communities need our people and especially our youth to smile again. We encourage the Committee to work with the other relevant authorizing Committees to repeal this section of the law so that IHS and Tribes can utilize scarce discretionary dollars in the most cost-effective way possible.

Facilities: Tribes recommend prioritizing facilities funding in FY 2020. On average, IHS hospitals are 40 years of age, which is almost four times more than other U.S. hospitals with an average of 10.6 years.[9] A 40 year old facility is about 26 percent more expensive to maintain than a 10-year facility. The facilities are grossly undersized—about 52%—for the identified user population, which has created crowded, even unsafe, conditions among staff, patients, and visitors. Increases will be used to increase maintenance and improvement on IHS facilities, speed up the funding of projects on the IHS Healthcare priority list, and improve sanitation conditions in Tribal communities. Investments in facilities will allow the care provided in our communities to be on par with other health systems in the United States. In Alaska, for example over 5,000 rural homes are considered unserved by running water and wastewater. Individuals, instead, must rely on "honey buckets" to dispose of waste. This is just unacceptable. The FY 2020 Budget Request proposes a ***decrease*** of nearly $66 million from the FY 2019 annualized continuing resolution (CR). NIHB emphatically opposes this decrease and encourages Congress do continue to build funding for facilities in FY 2020.

Advance Appropriations:

[8] 25 U.S.C. 1616l(d)

[9] *Almanac of hospital financial & operating indicators: a comprehensive benchmark of the nation's hospitals* (2015 ed., pp. 176-179): https://aharesourcecenter.wordpress.com/2011/10/20/average-age-of-plant-about-10-years/

As in past years, NIHB continues to request that the Administration support Advance Appropriations for IHS in its FY 2020 Budget Request. The 35 day partial government shutdown at the start of 2019 had a devastating impact the I/T/U system and the people it serves Tribes throughout the country reported rationed care, reduced services, loss of health care providers and some facilities closed altogether. This reckless shutdown destabilized Native health delivery and health care provider access; as well as Tribal Governments, families, children and individuals.

We uniformly request advance appropriation of IHS funding that becomes available one year or more *after* the year of the appropriations act in which it is contained. Thus, advanced appropriation provides more certainty to operate the Indian health care delivery system. This change in the appropriations schedule will allow Indian Health programs to effectively and efficiently manage budgets, coordinate care, enter into contracts, and improve health quality outcomes for AI/ANs. Advance appropriations for IHS would support the ongoing treatment of patients without the worry if—or when—the necessary funds would be available. Health care services require consistent funding to be effective. Advanced appropriations will help the federal government meet its trust obligations to Indian Country and bring parity to this federal health care system at no additional cost.

FY 2020 President's Budget Request

The FY 2020 President's Budget Request includes $5.945 billion for the Indian Health Service. This represents a $140 million increase from the FY 2019 enacted amount of $5.804 billion. While we appreciate the increase funding for Hospitals and Clinics and Purchased/Referred Care, several items in the FY 2020 request are of particular concern for NIHB and the Tribes.

Community Health Aide Program/Community Health Representatives

The President's Budget Request for FY 2020 proposes to phase out the Community Health Representatives Program (CHR) and replace it with the National Community Health Aide Program (CHAP). It cuts the CHR program by $39 million and invests $20 million for the CHAP program. The CHAP program has shown much success however, its expansion should not come at the expense of this critical, and already highly successful program. If this request were to be accepted, services provided would fall flat and neither program would likely be able to effectively operate. Furthermore, for generations, CHRs have been integral to the fabric of health delivery in Indian Country and Tribes do not wish to see this historic program discontinued. Ninety-six percent of CHR programs are operated by the Tribes in partnership with the IHS and provides one of the best examples of the Nation to Nation relationship between the Tribes and the Federal government. CHRs provide services like in-home patient assessment of medical conditions, providing glucose testing or blood pressure tests to determine if the patient should seek further care, and providing transportation for medical care. They also help interpret prescriptions which is critical to patient safety and the elimination of this program would be detrimental to the health and wellbeing of many Tribal communities. There are more than 1,600 CHRs representing over 250 tribes in all 12 IHS Areas and exported CHR program data in FY 2016 demonstrated that CHRs conducted 340,270 home visits and provided 1,102,164 patient contacts/services on a variety of health related conditions. However, it is likely that there are far more contacts are made in reality but not reflected in data due to reporting challenges associated with the RPMS system.

The NIHB recommendation for this line item would be to increase funding for the sole purpose of service delivery of CHR program services and functions. The CHAP program is also supported as a separate

recommendation. Tribes also look forward to meaningful consultation with the federal government in the event that significant alterations to life-changing Indian health programs are being considered.

In FY 2020, the NIHB recommends CHRs are funded at $83.2 million, which is an increase of $18.9 million above the FY 2017 enacted level.

Health Education Program
The President's FYs 2019 and 2020 budget proposed to discontinue funding the program and instead direct funds to health care services and staffing newly constructed facilities. Eliminating the health education program would create gaping holes in care for many Tribal communities. Too often, the Indian Health system does not have enough staff to meet the demand for its services and many AI/ANs rely on health education resources as their primary source of information about the Indian health system. The loss of health education funding would dissolve many opportunities for an AI/AN patient to receive communications regarding their own healthcare, while also limiting their access to available resources and information designed to assist them in making informed choices. Additionally, minimizing resources that effectively coordinate care for patients also greatly reduces the ability for IHS and Tribes to effectively maximize their resources and treat patients.

NIHB recommends funding the Health Education program at $39.7 million. This is an increase of $20 million from FY 2017 enacted.

Special Diabetes Program for Indians:
NIHB recommends that the Administration propose permanent enactment of the Special Diabetes Program for Indians (SDPI). In recent years, the highly successful program has only been renewed in short 1-2 year increments (and in 2017-18 just a few months!). This creates instability in the program, to the detriment of staff recruitment and retention, long-term planning, and overall effectiveness. The current authorization expires on September 30, 2019. In addition, SDPI has not received an increase in funding since FY 2004 which means the program has effectively lost about 25 percent in programmatic value over the last 15 years due to corresponding to inflation and the significantly increased costs of diabetes care. Any renewal or permanent enactment should ensure that inflation is built into final funding levels.

Few programs are as successful as SDPI at addressing chronic illness and risk factors related to diabetes, obesity, and physical activity. SDPI has proven itself effective, especially in declining incidence of diabetes-related kidney disease. The incidence of end-stage renal disease (ESRD) due to diabetes in American Indians and Alaska Natives has fallen by 54% - a greater decline than for any other racial or ethnic group. Treatment of ESRD costs almost $90,000 per patient, per year, so this reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and third party payers. We believe that permanent enactment of SDPI is a common-sense approach.

Support Funding of Tribes outside of a grant-based system
The health needs of Indian people are chronic and multi-faceted; such needs deserve to be addressed through committed, stable funding. In contrast, grant programs are temporary, unreliable, non-recurring, and unable to address the ongoing critical needs of Tribal communities. Under the grant making process, some Tribes receive assistance and benefit from somewhat consistent increases, while other Tribes do

not. This creates two pools of Tribes – those that have technical experience and financial resources receive funding, while many others without this capacity see no benefit in appropriated increases. The strings attached to federal grants in terms of reporting, limitations on use of funds, and timelines distract from patient care. Since 2008, 50% (about $40 Million) of the increases to the total Behavioral Health budget (Mental Health and Alcohol & Substance Abuse Programs) is due to a growth in special grant programs and initiatives rather than increases to existing Behavioral Health programs. Instead of project or disease specific grant funds, the IHS needs to prioritize flexible, recurring base funds.

Grants create a "disease de jour" approach, where the funding is tied only to an identified hot topic issue. For instance, if a patient presents with an "unfunded" diagnosis that is not covered by grants for specific disease categories that patient is left without many alternatives. This does not bode well for the many chronic diseases from which AI/ANs disproportionately suffer. For example, a large focus on the methamphetamine epidemic 10 years ago may have distracted from the rise in patients addicted to prescription pain medicine, thus contributing to the opioid crisis in Indian Country today. While the United States generally is now facing an opioid crisis, a particular service unit in one IHS area may struggle most with alcohol addiction and under the grant making process cannot redesign the available programs and services to meet Tribal community needs. As such, ***IHS should never use a grant program to fund ongoing critical Indian Health needs.***

Funding for ongoing health services in FY 2020 should be distributed through a fair and equitable formula rather than through any new grant mechanism or existing grant program. Across Indian Country, the high incidence of chronic health conditions like heart disease, suicide, substance abuse, diabetes, and cirrhosis is well documented. Grant funding used to address any Indian health issue creates limited and restrictive funding and access to culturally appropriate care.

Other Sources of Indian Health Funding

Medicaid

While the above recommendations address the IHS budget, the federal trust responsibility for health extends beyond the IHS. Proposals in the President's FY 2020 Budget Request, will have major fiscal impacts on IHS and Tribal health reimbursements that would devastate Tribal health. We urge the administration to work with Tribes and strengthen its Tribal Consultation practices on issues like Medicaid work requirements and block grants, so that fiscal strain doesn't unintentionally fall back to the IHS and Tribal Health programs. Decreasing Medicaid decreases scarce resources available to cover our cost of care, and further restrict the eligible patient population. This puts an unequal burden on the IHS budget which is so reliant on these resources to make up our funding shortfalls. American Indians and Alaska Natives already have access to health care through the IHS, so work requirements only serve to inhibit the use of Medicaid in Tribal communities.

Good Health and Wellness in Indian Country

The President's FY 2020 Budget request for the Centers for Disease Control and Prevention (CDC) is approximately $763 million below the FY 2019 enacted level. This includes a zeroing out the Good Health and Wellness in Indian Country (GHWIC) program (currently funded at $21 million). The Good Health and Wellness in Indian Country Program is CDC's largest investment in the wellbeing of American Indian and Alaska Natives. GHWIC funding must be restored. The thirty-five Tribes participating in the program have utilized community-driven, culturally adapted strategies to improve

public health in their communities. GHWIC is a lifeline for these communities who would otherwise have no public health investment. In fact, it is the only dedicated funding for AI/ANs at CDC. Given the success of the program, NIHB recommends that this program be increased to $32 million in FY 2020 to build public health infrastructure in Indian Country

Food Distribution Programs

The President's Budget for FY 2020 would also make major changes to the Supplemental Nutrition Assistance Program (SNAP) including $17.4 billion in cuts – amounting to one-fifth of the total SNAP budget. It would impose mandatory work requirements for all able-bodied individuals between 18 and 65 and reintroduces the controversial "Harvest Box" idea from last year, which would use a portion of benefits to buy and deliver a package of commodities to SNAP households. Approximately 25% of Native households currently utilize SNAP, but in some Tribal communities, over 50% of households are recipients of the program.

The President's FY 2020 Budget also proposes a $23 million cut to the Food Distribution Program on Indian Reservations (FDPIR) and proposes total elimination of the $998,000 FDPIR Nutrition Education program – the only Tribally-specific nutrition program in existence.

Conclusion

Thank you again for holding this important hearing and for the opportunity to offer testimony for the record. You can find a more detailed FY 2020 IHS Budget Request at www.nihb.org.